Flu Assessment Screening / Consent Form For School Kids

Please attach a copy of the front and back of your insurance card!

VFC **Insurance** **_____ CK / Cash / CC**

First name: _____ Last name: _____ Grade: _____

Date of Birth: _____ Gender: _____ Race: _____ Hispanic or Non Age: _____

Home address: _____

City: _____ State: _____ Zip: _____

Insurance Plan Name: _____

Insurance Id Number: _____ Group: _____

If covered under parent's plan – Name: _____ DOB: _____

Phone: _____ Gender: _____ Relationship to child: _____

Please answer the following questions, Including those getting the Flu Mist

- Are you sick today (fever, cough, nausea/vomiting)? Yes or No
- Do you have a serious allergy to eggs (meaning you are unable to eat them)? Yes or No
- Do you currently have Guillain-Barre Syndrome (severe muscle weakness or paralysis)? Yes or No
- Ever had a serious reaction to any previous flu vaccine or any vaccine? Yes or No

Flu Mist Only (Ages 5 -10 years)

- Have you ever been told you have wheezing or asthma? Yes or No
- Do you have a weakened immune system due to HIV/AIDS or any disease that effects immune system, long term use with drugs such as steroids, cancer treatment with radiation or medications? Yes or No
- Are you taking antiviral medications? Yes or No
- Receiving aspirin therapy or aspirin containing therapy? Yes or No
- Are you planning to have contact with in the next 7 days with anyone whose immune system is severely compromised and who must be in protective isolation (i.e. bone marrow transplant unit)? Yes or No
- Have you received any live virus vaccinations (MMR, chicken pox) in the past 4 weeks? Yes or No
- Are you pregnant or do you plan to become pregnant in the next 4 weeks? Yes or No

Please Read and Sign Below

This record will be kept on file at the Macon Co. Health Dept. It will record when the vaccine was given, the name of the manufacturer, the lot number and injection site. I have read and been offered a copy of the **V**accine **I**nformation **S**tatement and have had the opportunity to ask questions and had them answered to my satisfaction. I understand the benefits and risk of the vaccine to be given and give my consent to receive the injection. I give consent for my insurance (if applicable) to be billed, **and if denied**, I understand that I am responsible for the payment in full. By signing below, I acknowledge that I have been offered a copy and/or read the HIPAA Privacy Act and agree to the statements above.

Parent/Guardian Signature: _____ Date: _____

Please Print: _____ Phone: _____

Staff Use Only: Eligibility verified Online or Phone (initials) _____ Date: _____

Rev. 8/19

Flu Mist (5-10) **Date given: _____**

AstraZeneca Lot # Exp. date: VIS date: 8/15/19 STICKER

Administered by: _____ Route: Internasal

High Dose (65 +) **Date given: _____**

Sanofi Pasteur Lot # Exp. date: VIS date: 8/15/19 STICKER

Administered by: _____ Injection site: Rt Lt deltoid

Fluzone .5 (3+) **Date given: _____**

Sanofi Pasteur Lot # Exp. date: VIS date: 8/5/19 STICKER

Administered by: _____ Injection site: Rt Lt deltoid thigh

FluBlok (18-64) **Date given: _____**

Sanofi Pasteur Lot # Exp. date: VIS date: 8/15/19 STICKER

Administered by: _____ Injection site: Rt Lt deltoid